

# **Table of Contents**

Acknowle	dgements	2
Adviso	ory Council on Child and Adolescent Behavioral Health	2
Introducti	on	3
Purpose of	f the Guide: A Blueprint for Action	4
Part I.		
The Bu	urden of Child and Adolescent Behavioral Health Disorders	5
	oidemiology of Behavioral Health Disorders Among Children and scents in the United States	0.
The Tr	eatment and Cost Trends of Child and Adolescent Behavioral Health Disorders $ \ldots  \ldots  1$	2
Part II.		
The St	ate of Child and Adolescent Behavioral Health Treatment	4
Currer	nt Challenges, Future Opportunities: Recommendations for Action	4
Appendic	es	
Appen	dix 1: Abbreviations3	1
Appen	dix 2: Glossary3	2
Appen	dix 3: ICD-9 Codes	4
Appen	dix 4: References	5
List of Fig	gures	
Figure 1.1.	Estimated Prevalence of Emotional/Behavioral Disturbances among Children and Adolescents in the United States	5
Figure 2.1.	Typical Age Ranges for Presentation of Selected Disorders	.1
Figure 3.1.	Mental Health Treatment Costs 2003, by age	2
List of Tal	bles	
Table 1.1.	Adjusted Mean Costs for Privately-Insured Children and Adolescents	6
Table 1.2.	Privately-Insured Children and Adolescents Receiving Psychotropic Medication	7
Table 1.3.	Employer Costs Associated with Caregiving Employees	8
Table 3.1.	Child and Adolescent Mental Health Expenditures, 2003	2
Table 4.1.	Comfort Level with Diagnoses among Pediatricians	6
Table 4.2.	Comfort of Using Medication among Pediatricians	6
List of Bo	xes	
Box 4.1.	Providers of Child and Adolescent Behavioral Health Care	5
Box 4.2.	Controversies Related to Specific Psychotropics	.7
Box 4.3.	Evidence-Based Treatments for Pediatric Mental Health Care	
Box 4.4.	The Individuals with Disabilities Education Act	2
Box 5.1.	Residential Treatment Centers	6
Box 5.2.	Michelin Health Advocate Program	7

# **Acknowledgements**

The Advisory Council on Child and Adolescent Behavioral Council was established in 2008 through a contract from the Substance Abuse and Mental Health Service Administration, U.S. Department of Health and Human Services. The National Business Group on Health created the Advisory Council to develop recommendations to improve the delivery of child and adolescent mental health care.

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# Introduction

In 2005, the National Business Group on Health released *An Employer's Guide to Behavioral Health Services*. The *Guide* provided employers the information necessary to standardize the delivery of behavioral health services in the general medical and behavioral health settings. The Business Group is now expanding upon this Guide with information specific to child and adolescent behavioral health.

Youth with behavioral health problems receive treatment from many different sectors, including child welfare, juvenile justice, mental health, general medical and education; unfortunately, each sector is fragmented from the others, overburdened, and lacking clear responsibility or accountability for providing services. As a result, few children receive the treatment needed.

Like other chronic health issues, the effects of child and adolescent mental health disorders can be far reaching. For the individual child, the disorder and its associated stigma can bring about lifelong challenges. Caring for a child with a mental health disorder can also have a significant impact on the family and the workplace. Parent caregivers are more likely to report increased work absences, reduced productivity and job termination.

In 2008, the National Business Group on Health convened the Advisory Council on Child and Adolescent Behavioral Health to develop recommendations for the comprehensive delivery of employer-sponsored child and adolescent mental health benefits. The Advisory Council identified common barriers to care that should be addressed as well as employer-based strategies to help reduce caregiver burden.

# **Purpose of the Guide: A Blueprint for Action**

The *Employer's Guide to Child and Adolescent Mental Health* was designed to help employers improve the delivery of child and adolescent behavioral health services, as well as provide services for family caregivers.

The recommendations in this report provide solutions to the issues highlighted by the Advisory Council and focus on employer-based strategies for health plans, Employee Assistance Programs and workplace policies.

Specifically, these recommendations can help:

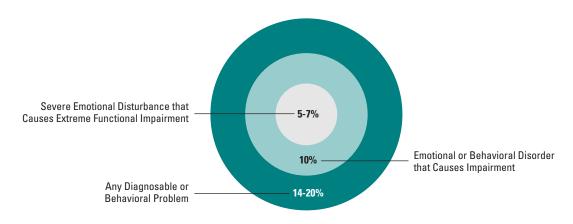
- Improve the delivery of behavioral health care services in both the general medical and mental health sectors;
- Improve employee health and productivity;
- Improve the health status of the future workforce;
- Reduce unnecessary healthcare expenditures; and
- Reduce the use of Family Medical Leave (FMLA).

# **PART I**

# The Burden of Child and Adolescent Behavioral Health Disorders

Research suggests that between 14 percent to 20 percent of children and adolescents, about one in every five, have a diagnosable emotional or behavioral disorder.<sup>1</sup> An estimated 10 percent of children have an emotional or behavioral disorder that causes impairment.<sup>2</sup> Between 5 percent and 7 percent of children have a severe emotional disturbance (SED) that causes extreme functional impairment (see figure 1.1).<sup>1</sup>

Figure 1.1. Estimated Prevalence of Emotional/Behavioral Disturbances among Children and Adolescents in the United States.



Sources: RAND. Mental Healthcare for Youth: Who Gets It? Who Pays? Where Does the Money Go? Publication No. RB-4541. Santa Monica, CA: RAND; 2001; U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General—Executive Summary. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health; 1999.

## IMPACT ON THE WORKPLACE

Children with any level of functional impairment can affect the workplace through increased medical expenditures and decreased productivity of caregivers.

## Direct Costs<sup>ii</sup>

Privately-insured youth account for 70 percent of the child and adolescent population and 50 percent of the total spending (\$18.8 billion) for child and adolescent mental health.<sup>2</sup> From 1997 to 2000, Medstat MarketScan data detailed paid charges for privately-insured children and adolescents, including patient payments (i.e., copays, deductibles) and insurance plan payments. On average, child and adolescent

<sup>&</sup>lt;sup>1</sup>Functional impairment is defined as "difficulties that substantially interfere with, or limit, a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, cognitive, behavioral, communicative or adaptive skills." For example, impairment may limit the ability to function in a classroom setting.<sup>3</sup>

<sup>&</sup>lt;sup>ii</sup>Cost data represents the most recent available. Despite the importance of increasing costs among children and adolescent behavioral health services, recent cost data is limited for several reasons:<sup>4</sup>

<sup>•</sup> Very little cost data distinguish children and adolescents from adults.

<sup>•</sup> Cost research on child and adolescent behavioral health is fragmented and may not consider the full care continuum across multiple treatment sectors.

<sup>·</sup> Some cost data may be incomplete because many primary health care costs are not properly coded as mental health codes.

behavioral health disorders cost \$937 annually for outpatient care and \$5,384 for inpatient care. Table 1.1 shows further breakdown of cost per day and annual costs per youth by diagnostic category.

TABLE 1.1. Adjusted Mean Costs for Privately-Insured Children and Adolescents (includes patient copays and health plan payments)

## **MEAN COST (ADJUSTED)**

	MILAN COST (ADSOSTED)	
Cost and Diagnostic Group	Inpatient Mental Health Care	Outpatient Mental Health Care
Cost Per Day (dollars)	\$677	\$168
Adjustment Disorders	\$454	\$113
Anxiety Disorders	\$418	\$173
Bipolar Disorders	\$826	\$264
Depressive Disorders	\$604	\$160
Hyperactivity	\$844	\$187
Other Mental Health Disorders	\$758	\$180
Psychosis	\$820	\$351
Substance Abuse	\$784	\$373
Annual Cost Per Youth (dollars)	\$5,384	\$937
Adjustment Disorders	\$2,373	\$815
Anxiety Disorders	\$1,718	\$1,021
Bipolar Disorders	\$7,180	\$2,073
Depressive Disorders	\$5,288	\$1,153
Hyperactivity	\$7,309	\$763
Other Mental Health Disorders	\$9,700	\$1,236
Psychosis	\$6,495	\$2,130
Substance Abuse	\$5,915	\$1,823

Source: Martin A, Leslie D. Psychiatric inpatient, outpatient, and medication utilization and costs among privately-insured youths, 1997-2000. Am J Psychiatry 2003;160:757-764.

Psychotropic medications account for more than 10 percent of behavioral health expenditures.<sup>5</sup> For privately-insured youth, psychotropic expenditures vary by diagnostic category. Between 1997 and 2000 the mean cost per month supply of medication across all diagnoses was \$46.<sup>4</sup> Cost per month to treat psychosis was the most expensive (\$71 per month) and hyperactivity was the least expensive (\$37 per month).<sup>4</sup> These costs are based on aggregate data alone rather than specific drug class and refer only to outpatient care.

# TABLE 1.2. Privately-Insured Children and Adolescents Receiving Psychotropic Medication (includes patient copays and health plan payments)

#### **OUTPATIENTS RECEIVING PSYCHOTROPIC MEDICATION**

Cost and Diagnostic Category	Mean Cost (adjusted)
Cost per Month's Supply of Medication (dollars)	\$46
Adjustment Disorders	\$47
Anxiety Disorders	\$57
Bipolar Disorders	\$58
Depressive Disorders	\$52
Hyperactivity	\$37
Other Mental Health Disorders	\$57
Psychosis	\$71
Substance Abuse	\$56
Percent of Youth Outpatient Costs	39%
Adjustment Disorders	31%
Anxiety Disorders	43%
Bipolar Disorders	47%
Depressive Disorders	37%
Hyperactivity	47%
Other Mental Health Disorders	36%
Psychosis	52%
Substance Abuse	41%

Source: Martin A, Leslie D. Psychiatric inpatient, outpatient, and medication utilization and costs among privately-insured youths, 1997-2000. Am J Psychiatry 2003;160:757-764.

#### **Indirect Costs**

Both families and employers experience indirect costs associated with child and adolescent behavioral health. Youth with behavioral health disorders incur more missed school days and experience reduced potential for education, employment, and income. Indirect costs to the employer include absenteeism and reduced productivity of the caregiver parents.

It is estimated that approximately 8.6 percent of a company's employees care for a child with special needs (including mental disorders).<sup>6</sup> The dual responsibility of caregiver and employee can affect an individual emotionally, financially and physically.

Caregiver burden refers to the "impact that living with a patient (i.e., child) has on family's daily routine and health." Nearly 40 percent of parents caring for a child diagnosed with an emotional or behavioral impairment report this burden. Financial problems among privately-insured families caring for a child with a behavioral health problem are common.

- Forty-two percent report annual out-of-pocket spending of greater than \$500.
- Thirty percent report that their child's health care has caused financial problems.
- Twenty-five percent report needing additional income to care for the child.8

The availability and adequacy of childcare is also directly related to caregiver strain. The Americans with Disabilities Act (ADA) prohibits the expulsion of children with mental health problems from government-run childcare or educational programs. Private childcare agencies are held to the same regulatory standard but can expel children for disruptions. As a result, parents report difficulty in locating care for their child. In one study, children with emotional or behavioral issues were 20 times more likely to be asked to leave childcare than children without these issues. The interval of the care of the care of the children without these issues.

## Impact on Productivity

The strongest predictor of caregiver burden is the success of work-life integration. Workplace policies with limited flexibility or a perceived lack of support create barriers to ongoing employment for caregiver parents. According to caregivers, supervisors and coworkers consider work interruptions for child mental health problems differently than work interruptions for other chronic medical conditions. Supervisors and coworkers often misunderstand the ongoing support needed for children with emotional or behavioral health problems.

Financial pressures, childcare difficulties and frequent behavioral health-related appointments often lead to absenteeism, presenteeism and termination of employment. Employees caring for a child with a mental health diagnosis report, on average, 1.4 lost work days and 1.2 early departures from work in the month prior. Among privately-insured families caring for a child with behavioral health problems:

- seventeen percent report spending more than four hours per week arranging care;
- thirty-six percent have cut work hours to care for the child; and
- seventeen percent have stopped working because of the child's health.8

Using methodology and data from previous caregiver cost studies, table 1.3 details the costs associated with caregiving.

TABLE 1.3. Employer Costs Associated with Caregiving Employees

Cost Drivers	Frequency	Average Salary/Cost	Total Impact
Absenteeism (full-day and early departures)	1—2 days/month	\$588/week (women) \$731/week (men)	\$1,411—\$2,822/year \$1,754—\$3,508/year
Presenteeism	4 hours/week	\$588 (women) \$731 (men)	\$2,940/year \$3,655/year
Replacement Costs	17% of all caregiver employees	30—50% entry level 150% mid-level 400% specialized, high-level executive	Based on individual salary
Job-Share Costs (full-time to part-time)	36% of all caregiver employees	\$2,306/employee for large business	Based on individual salary

Sources: Burton WN, Chen C, Conti D, et al. Caregiving for ill dependents and its association with employee health risks and productivity. *J Occup Enviro Med.* 2004;46:1048-1056; Metlife Mature Market Institute. *Caregiving Cost Study: Productivity Losses to U.S. Businesses.* New York; 2006; Center for Child and Adolescent Health Policy, MassGeneral Hospital for Children. *Children with Special Needs and the Workplace: A Guide for Employers*, 2004. Available at www.massgeneral.org/ebs. Accessed February 18, 2009.

# Impact on Healthcare Utilization

Caregiving affects employer healthcare costs in less obvious ways. In one study, caregivers were more likely to report fewer hours of sleep and more signs of anxiety or depression in the 30 days before the survey than non-caregivers. <sup>14</sup> They had a significantly higher number of health risks such as smoking, lack of physical activity and the use of medications to relax. <sup>14</sup> The corporate costs of decreased health are less obvious, but they can be substantial.

Caregiver burden is also associated with increased healthcare utilization for the ill dependent.<sup>7,15</sup> In one study, perceived burden was the sole predictor of a dependent's use of health services.<sup>15</sup> Another study associated caregiver burden with a three- to five-fold increase in the dependent's use of specialty mental service.<sup>7</sup>

# The Epidemiology of Behavioral Health Disorders among Children and Adolescents in the United States

Youth are affected by many of the same behavioral health problems as adults. However, children are rarely labeled with mental illness. Instead, youth with less severe mental health problems can be described as having emotional disturbances. Children and adolescents with severe mental health problems that interfere with daily functioning are described as having severe emotional disturbances (SEDs).<sup>16</sup>

Anxiety is the most common behavioral health disorder among children. Approximately 13 percent of 9-to 17-year-old children have an anxiety disorder (i.e., phobia, panic disorder, generalized anxiety disorder, obsessive-compulsive disorder). Attention Deficit/Hyperactivity Disorder (ADHD) is another common disorder among school-age children. The percentage of children ages 3 to 17 who have been diagnosed as having ADHD has increased from 5.5 percent in 1997<sup>18</sup> to 7.4 percent (4.7 million) in 2006. Other common problems that affect children and adolescents include depression, eating disorders, autism, child abuse and suicidality.

- Approximately 2 percent of children and 8 percent of adolescents suffer from major depression.<sup>17</sup>
- Lifetime eating disorder prevalence rates for females average 0.5 percent to 3.7 percent for anorexia nervosa, 1.1 percent to 4.2 percent for bulimia nervosa and 2 percent to 5 percent for binge-eating disorder.<sup>20</sup>
- Approximately 5.5 per 1,000 youth ages 4 to 17 had a diagnosis of autism in 2003.<sup>21</sup>
- Approximately 900,000 children were considered abuse victims in 2006, a rate of 12 per 1,000 children; 64 percent of the children were victims of child neglect; 7 percent were victims of emotional abuse; 9 percent were victims of sexual abuse; and 16 percent were victims of physical abuse.<sup>22</sup>
- The suicide death rate for youth ages 15 to 19 was 7.7 deaths per 100,000 resident population. For youth ages 5 to 14, the suicide death rate was 0.7 deaths per 100,000 resident population.<sup>23</sup>

Substance use and abuse are also concerns among school-age children and adolescents. For example:

- Approximately 9.5 percent of adolescents ages 12 to 17 reported current illicit drug use in 2007; 6.7 percent used marijuana, 3.3 percent abused psychotherapeutic drugs, 1.2 percent used inhalants, 0.7 percent used hallucinogens and 0.4 percent used cocaine. Illicit drug use increases with advancing age during adolescence and young adulthood and then begins to decline during the early 20s.<sup>24</sup>
- Approximately 15.9 percent of adolescents ages 12 to 17 reported using alcohol within the previous 30 days in 2007; 9.7 percent report binge drinking and 2.3 percent report heavy alcohol use.<sup>24</sup>

Child and adolescent behavioral health problems typically present themselves within distinct age brackets. The onset of attachment and pervasive developmental disorders (e.g., autism) can be as early as age 1. Disruptive behaviors and mood disorders can present as early as mid to late childhood (3 to 12 years), while substance abuse and psychosis typically present later in adolescence (12 to 17 years).<sup>25</sup>

FIGURE 2.1. Typical Age Ranges for Presentation of Selected Disorders

# AGE (YEARS)

Disorder	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Attachment																		
Pervasive developmental disorder																		
Disruptive behavior (i.e., ADHD)																		
Mood/anxiety disorder																		
Substance abuse																		
Adult type psychosis																		

Source: World Health Organization. Mental Health Policy and Service Guidance Package: Child and Adolescent Mental Health Policies and Plans. Geneva, Switzerland: World Health Organization, 2005.

# The Treatment and Cost Trends of Child and Adolescent Behavioral Health Disorders

# **OVERALL TREATMENT TRENDS**

An estimated 9 to 12 percent of children under the age of 18 receive treatment for emotional or behavioral problems annually.  $^{26,27}$  In 2006, more than half (57 percent) of youth seeking treatment from the mental health or general medical sectors were adolescents ages 12 to 17; young children (ages 1 to 5) represented only 5 percent.  $^{26}$ 

Youth accounted for 16 percent (\$18.8 billion) of the total \$121 billion spent by all payment sectors on mental health treatment (see figure 3.1).<sup>5</sup> Among youth, mental health treatment represented 9.3 percent of total healthcare expenditures.<sup>5</sup> Table 3.1 details total child and adolescent mental health expenditures by treatment setting.

Ages 65+

\$16.1 billion (13%)

\$18.8 billion (16%)

Ages 18-64

FIGURE 3.1. Mental Health Treatment Costs 2003, by age

Source: Mark T, Harwood H, McKusick D, King E, Vandivort-Warren R, Buck J. Mental health and substance abuse spending by age, 2003. J Behav Health Serv Res, Epub 2008;35(3):279-289.

(71%)

TABLE 3.1. Child and Adolescent Mental Health Expenditures, 2003

Provider/Setting	Amount (billions)	Percentage
Multiservice Mental Health Organizations <sup>a</sup>	\$5.29	28.1%
Hospital Inpatient	\$4.67	24.8%
Prescription Medications	\$2.67	14.2%
Physicians	\$2.24	11.9%
Other professionals (nurses, social workers, psychologists)	\$1.71	9.1%
Specialty Substance Abuse Centers	\$0.91	4.8%
Insurance Administration	\$1.33	7.1%
Total Expenditures	\$18.8 billion	100%

Note:

Source: Mark T, Harwood H, McKusick D, King E, Vandivort-Warren R, Buck J. Mental health and substance abuse spending by age, 2003. J Behav Health Serv Res, Epub 2008;35(3):279-289.

a. Multiservice mental health organizations (MSMHOs) are generally nonhospital facilities that provide a variety of mental health services.

# INPATIENT AND OUTPATIENT CARE

The advent of managed care in the 1980s and 1990s significantly changed the face of behavioral health care in the general medical and mental health sectors. Managed care created a movement away from institutionalization in hospitals and residential treatment centers. As such, the length of inpatient stays decreased significantly over the past two decades.<sup>4, 28</sup>

- The median number of inpatient days per hospital mental health discharge among children and adolescents decreased 63 percent between 1990 and 2000, from 12.2 days to 4.5 days.<sup>28</sup>
- From 1997 to 2001 alone, inpatient days for youth with mental health disorders decreased 20 percent, resulting in a \$1,216 reduction in inpatient costs per patient.
- From 1986 to 1996, inpatient services dropped from two-thirds of mental health costs among children and adolescents to one-third.<sup>29</sup>

The move from inpatient care resulted in higher utilization of hospital and provider outpatient services. In 2006 more than 70 percent of youth seeking care received treatment in an outpatient setting. <sup>26</sup> However, the mean number of outpatient visits per patient also declined over the past two decades. <sup>4</sup> Between 1997 and 2000, the average number of outpatient visits per patient for all mental health disorders decreased by 11.3 percent. <sup>4</sup>

# PRESCRIPTION DRUGS

During this period of decreased service utilization, the rates of antidepressant, stimulant and other psychotropic drug prescriptions increased. New psychotropic drugs were made available and managed care organizations relied heavily on their use.

- Between 1993 and 2002, the number of office visits by youth that included an antipsychotic prescription increased six-fold from 201,000 to 1,224,000 respectively.<sup>27</sup> Prescription of antipsychotics increased nearly five-fold.<sup>30</sup>
- Between 1998 and 2002, the prevalence of commercially-insured youth prescribed antidepressants increased 49 percent, from 1.59 percent to 2.37 percent.<sup>31</sup> Between 2002 and 2005, the prevalence continued to increase 9.2 percent annually.<sup>31, 32</sup>

As a result, the latest available data indicate that 74 percent of youth who sought mental health treatment (4.5 million) received prescription medications.<sup>26</sup>

Psychotropic utilization and their associated costs account for an appreciable, and growing, portion of mental health expenditures. Trends over the past decade show that higher prescription prices contributed to increased expenditures across all psychotropic drugs.<sup>4</sup> In 2003, prescription drugs accounted for 14 percent of child and adolescent behavioral health treatment costs among all payment sectors (\$2.67 billion).<sup>5</sup>

Stimulants and antidepressants are first-line treatments and therefore account for the majority of the psychotropic costs among children and adolescents. While stimulants are the most highly utilized treatments among all groups of children,<sup>33</sup> adolescents are prescribed both stimulants and antidepressants nearly equally.<sup>2</sup> Nearly 50 percent of adolescent psychotropic costs can be attributed to antidepressants, compared with 10 percent of psychotropic costs for children ages 1 to 5 and 28 percent for children ages 6 to 11.<sup>33</sup>

# Part II

# The State of Child and Adolescent Behavioral Health Treatment

Youth mental health treatment stretches across many different service systems, including child welfare, juvenile justice, mental health, general medical and education; however, each agency is fragmented from the others, overburdened, and lacks clear responsibility or accountability for providing services.<sup>34</sup> According to the U.S. Surgeon General, "growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them."<sup>35</sup>

It is estimated that two-thirds of children do not receive the mental health care they need.<sup>36</sup> Untreated mental health disorders among youth can lead to academic and vocational failure, social isolation, substance abuse, health problems, suicide and incarceration.<sup>34</sup> The U.S. Surgeon General states that "no other illnesses damage so many children so seriously."<sup>37</sup> Nearly half of all individuals who have mental illness during their lifetime report that it started before age 14.<sup>38</sup>

The private mental healthcare delivery system—the system that delivers employer-sponsored behavioral health services—faces many of the same challenges as the public system. In the past, access has been stymied by higher out-of-pocket costs because of unequal cost-sharing, visitation limits and lifetime expenditures. New mental health parity legislation (effective January 2010) will improve patient costs by equalizing behavioral healthcare benefits with that of general medical benefits.

The following section describes some of the current issues facing the delivery and financing of child and adolescent behavioral health care in the United States. These issues will not be affected by the implementation of mental health parity.

## PROVIDER CHALLENGES

#### **Lack of Mental Health Professionals**

A lack of specialty mental health providers continues to be a significant barrier to the delivery of pediatric mental health treatment. In 2000 only 6,650 child psychiatrists existed<sup>39</sup> for the 15 million children needing mental health services nationwide.<sup>40</sup> The lack of child psychiatrists is even more pressing in rural areas. Only 5 percent of small rural counties have a child psychiatrist; only 25 percent have a general psychiatrist.<sup>41</sup>

One in four parents finds it difficult to obtain specialized mental health services for their child. Locating a specialist, long waits for an appointment and higher out-of-pocket costs—the effect of differing levels of coverage for mental health care—are frequent barriers.<sup>42</sup> As a result, nearly 60 percent of adolescents referred by their primary care physician for mental health services never receive them.<sup>43</sup>

#### **BOX 4.1. Providers of Child and Adolescent Behavioral Health Care**

**School counselors** help students understand and deal with social, behavioral and personal problems. Counselors emphasize preventive and developmental counseling to enhance personal, social and academic growth.<sup>44</sup> *Educational Requirements*:<sup>44</sup>

- Master's degree required by most states.
- State School Counseling Certification required by most states.

**School psychologists** work with students in elementary and secondary schools. School psychologists evaluate students and collaborate with teachers, parents and school personnel to address students' learning and behavioral problems.<sup>45</sup>

Educational Requirements:

A specialist degree (EdS) or its equivalent is required in most states.<sup>45</sup>

**Psychiatrists** assess and treat mental illnesses through a combination of psychotherapy, psychoanalysis, hospitalization and medication.<sup>46</sup>

Educational Requirements:46

- Medical degree (MD or D0)
- Board eligible or certification as a psychiatrist or child psychiatrist
- State licensure

**Psychologists** interview, assess, diagnose and treat children and adolescents with mental health problems. Treatment can be provided to the individual or family and may include behavior modification programs.<sup>44</sup> *Educational Requirements*:<sup>47</sup>

- Doctorate in psychology (PhD, PsyD, EdD)<sup>a</sup>
- State certification/licensure or, if not required, two years of supervised counseling

**Social workers** provide social services and assistance to improve the social, psychological and academic functioning of children and to maximize the well-being of families. They interview, assess, diagnose and treat children and adolescents with mental health problems.<sup>46</sup>

Educational Requirements:46

- Certification (LCSW, LICSW, CSW) or master's degree in social work
- State licensure may be required

**Professional counselors** work with individuals, families and groups to address and treat mental and emotional disorders. They are trained in a variety of therapeutic techniques used to address various issues issues.<sup>47</sup> *Educational Requirements*:<sup>47</sup>

- Master's degree required by most states
- State licensure (in some states, marriage and family counselors can provide care to children)

**Pediatricians and family physicians** examine patients, diagnose illnesses and administer treatment for people suffering from injury or disease. Pediatricians specialize in treating youth under the age of 18; family physicians treat all ages.

Educational Requirements:47

- Medical degree (D0 or MD)
- State licensure required
- Board certification in specialty (family medicine, pediatrics, etc.)

#### Note:

a. Some states have permitted master's level psychologists practicing before a given date to maintain their psychologist license. Otherwise, master's level training is no longer adequate for licensure as a psychologist.

# **Primary Care Physicians**

Until recently, primary care physicians (PCPs) who diagnosed children with mental health issues would refer patients to providers specializing in such conditions.<sup>48</sup> Financial limitations and a shortage of specialists<sup>49</sup> have compelled PCPs to assume more responsibility for these services. However, fewer than 30 percent of pediatricians believe that they should be responsible for treating child mental health disorders other than ADHD.<sup>50</sup> Many are uncomfortable treating mental health disorders.<sup>51, 52</sup> Combined with time and reimbursement concerns, some providers rely too heavily on psychotropic medication for mental health treatment.<sup>9</sup> However, research suggests that for child and adolescent depression and anxiety disorders, cognitive-behavioral therapy paired with appropriate psychotropic medication is more effective than medication alone, particularly in the short run.<sup>53-55</sup>

**TABLE 4.1. Comfort with Diagnoses among Pediatricians** 

Diagnoses	Percent of Pediatricians Comfortable
Anxiety/depression	56.0%
ADHD	84.6%
Bipolar affective disorder	9.9%

Source: Fremont WP, Nastasi R, Newman N, Roizen NJ. Comfort level of pediatricians and family medicine physicians diagnosing and treating child and adolescent psychiatric disorders. *Int J Psychiatry in Med.* 2008;38:153-168.

**TABLE 4.2. Comfort Using Medication among Pediatricians** 

Diagnoses	Percent of Pediatricians Comfortable
Stimulants	80%
Antidepressants	37%
Mood stabilizers	19%
Antipsychotics	11%

Source: Fremont WP, Nastasi R, Newman N, Roizen NJ. Comfort level of pediatricians and family medicine physicians diagnosing and treating child and adolescent psychiatric disorders. *Int J Psychiatry in Med.* 2008;38:153-168.

The scientific literature has also identified a number of quality problems in the prescription of psychotropic drugs to children.

- Many medications, including psychotropics, continue to be prescribed to children although few have Food and Drug Administration (FDA) approval for children.
- There are no nationally defined standards for the prescribing and monitoring of psychotropic drugs.
- Of children who are prescribed psychotropic medications, 30 percent do not have a psychiatric diagnosis documented in their medical records.<sup>43</sup>

# **BOX 4.2. Controversies Related to Specific Psychotropics**

#### **ANTIDEPRESSANTS**

Antidepressants can be an effective treatment for child and adolescent depression. However, recent research has shown that antidepressants may increase suicidal ideation and behavior in some youth with major depressive disorder (MDD). The FDA issued a "black box warning" for physicians treating children and adolescents for depression, obsessive-compulsive disorder (OCD), and other emotional disturbances and mental illnesses. The "black box warning" mandated revised labeling of antidepressants and expanded warnings alerting healthcare providers of the dangers of these drugs. The FDA guidelines state that:

"All pediatric patients being treated with antidepressants for any indication should be observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. Such observation would generally include at least weekly face-to-face contact with the patients or their family members or caregivers during the first four weeks of treatment, then every other week visits for the next four weeks, then at 12 weeks, and as clinically indicated beyond 12 weeks. Additional contact by telephone may be appropriate between face-to-face visits." 56

The FDA also recommends that physicians counsel families and caregivers about the need to monitor pediatric and adult patients for the emergence of anxiety, irritability, agitation, sudden behavior changes and other symptoms associated with a clinical worsening of depression and/or an increase in suicidality.<sup>56</sup>

In response to the "black box warning," pediatricians decreased their use of antidepressants in pediatric patients.<sup>51</sup> However, no causal role for antidepressants in increasing suicides has been established.<sup>57</sup> Physicians' decreased use of the medication may prevent some from receiving the treatment they need.

## **STIMULANTS**

Stimulants are the most commonly prescribed psychotropic for children. For many, stimulants have successfully mitigated symptoms related to ADHD. However, many parents are concerned about the increasing prevalence of ADHD and the increasing use of stimulants to treat it. One survey found that 38 percent of parents believed that too many children in the United States were on medication for ADHD.<sup>58</sup> Fifty-five percent of parents whose children were diagnosed with ADHD were reluctant to begin their child on stimulants based on information they heard or read in the lay press.<sup>58</sup> While some children may be overmedicated, many children who need medication and therapy are receiving no treatment or inadequate treatment.

#### **ANTIPSYCHOTICS**

Antipsychotics are being prescribed in increasing numbers. However, the FDA has approved only three antipsychotics for use in children: haloperidol, thioridazine hydrochloride and pimozide.<sup>27</sup> New research suggests that providers are reducing their use of first-generation antipsychotics in favor of second-generation "atypical" antipsychotics.<sup>59</sup> Studies indicate that 92 percent to 96 percent of new antipsychotic drug users under the age of 20 were given an atypical antipsychotic.<sup>27,60</sup> While these drugs lack the severe neurological effects of first-generation antipsychotics, no clinical testing has been done in children.<sup>61</sup> Thus, the FDA has approved none of the most common six—Clozaril, Risperdal, Zyprexa, Seroquel, Abilify and Geodon—for use in children. Doctors can only prescribe them as "off-label" medications.<sup>51</sup>

# **EVIDENCE-BASED PRACTICES (LACK OF STANDARDS OF CARE)**

Evidence-based medicine refers to "the use of intervention strategies for which there is scientific evidence supporting their effectiveness and safety for a given indication and population." A limited but growing number of psychotropic and psychosocial interventions have been proven effective for the pediatric population. However, the adoption and implementation of evidence-based treatment modalities for children is uncommon due to a shortage of professionals, the lack of reimbursement for coordination of care and other factors. Only one-third of children with mental health problems currently receive treatment, and even fewer receive evidence-based care. When evidence-based care is implemented, fidelity to a treatment protocol that does not consider familial, social or cultural influences threatens effectiveness.

Pediatric mental health disorders can require psychosocial interventions that differ from the traditional therapies provided to adults.  $^{62}$ 

- Family-focused treatments, <sup>62, 64</sup> interpersonal therapy <sup>62</sup> and cognitive-behavioral therapy <sup>62</sup> are reported to be effective outpatient psychotherapies for children.
- Intensive case management, therapeutic foster care and multisystemic home-based interventions have proven effective for children requiring more intensive care.<sup>62,64</sup> These services are typically less restrictive and less costly than inpatient care and have been shown to have better patient outcomes.
- Group homes, residential treatment centers and hospitals have not been proven effective for all children<sup>64</sup> but may be necessary in cases of self-endangerment or severe behavioral disorders.
- Unlike adults, nearly 80 percent of children receive treatment for emotional or behavioral problems in the school system. School-based interventions such as targeted classroom-based management<sup>62, 64</sup> and behavioral consultation<sup>64</sup> have proven effective in reducing aggressive and disruptive behaviors.

#### **BOX 4.3. Evidence-Based Treatments for Pediatric Mental Health Care**

Research suggests that effective treatments for pediatric mental health problems beyond traditional inpatient and outpatient care may include the following:

#### INTENSIVE CASE MANAGEMENT

The purpose of targeted clinical case management is to coordinate service delivery, ensure continuity and integrate services. Case management helps children interact successfully in the community and limits the need for out-of-home placement. Case loads are typically small (10 to 12 patients per case manager), allowing for daily 24-hour coverage. Services are based on the specific needs of the child and his or her family and are made available for as long as necessary.<sup>65</sup>

## **MULTISYSTEMIC HOME-BASED INTERVENTIONS**

Multisystemic therapy is a community-based treatment that uses an intensive, home-based model of service delivery for children and adolescents with antisocial or aggressive traits. 66 This intervention addresses the multidimensional factors that contribute to behavioral problems. It permits the therapist access to the home environment and the systemic effect of that environment on the patient. The intervention typically lasts approximately four months and is considered a cost-saving measure in that it can prevent out-of-home placements, such as incarceration, residential treatment and hospitalization. 66

#### THERAPEUTIC FOSTER CARE

Therapeutic foster care is considered the least restrictive form of out-of-home therapeutic placement for children and adolescents with severe emotional disorders (SEDs). Care is delivered in private homes with specially trained foster parents who act as caregivers and therapists. Frequent contact between case managers or care coordinators and the treatment family is expected. Research studies have demonstrated that therapeutic foster care can cost half that of residential treatment center placement for certain populations. In one study, previously hospitalized youth who entered therapeutic foster care showed more improvements in behavior. They had lower rates of reinstitutionalization than their peers who entered other settings such as out-of-hospital programs, residential treatment centers or the homes of relatives. Furthermore, the treatment costs of youth in the other settings.

#### THERAPEUTIC NURSERIES FOR CHILDREN

Also known as therapeutic behavioral services (TBS), therapeutic nurseries for children may be helpful for preschool-age children with serious behavioral problems, including developmental disabilities or SEDs. TBS are designed to support children who are at risk for a higher level of care, such as inpatient hospitalization. TBS can be provided in the patient's home, in the community or in a childcare setting. The services are not a replacement for childcare. Researchers have found that therapeutic nursery programs are an effective method of treatment. These comprehensive programs improve behavior and spur social and emotional growth.<sup>70</sup>

# **COLLABORATIVE CARE/COORDINATION OF CARE**

Strong evidence supports the use of "collaborative care" for behavioral health disorders in primary care practice settings (e.g., pediatric offices). For effective collaborative care, providers must invest significant time on non-face-to-face aspects of treatment. However, the lack of time and incentive (e.g., reimbursement) limits implementation. As a result, parents may spend a significant amount of time coordinating care.

The collaborative care model typically focuses on mental health treatment in the general medical setting (versus specialty behavioral healthcare setting). Collaborative care interventions have two key elements.

The first is case management by nurses, social workers or other trained staff. These professionals facilitate screening, coordinate an initial treatment plan and patient education, arrange follow-up care, monitor progress, and modify treatment if necessary. The second engages a consulting psychiatrist. In this consultation, the psychiatrist advises the primary care treatment team about their patient caseload.

The documented benefits of collaborative care for depression include:16

- higher rates of evidence-based depression treatment (i.e., antidepressant medication and/or psychotherapy);
- better medication adherence and compliance;
- reduction in symptoms and earlier recovery;
- improved quality of life;
- higher satisfaction with care;
- improved physical functioning; and
- increased labor supply.

## REIMBURSEMENT

The reimbursement of specific services, conditions or providers by private insurers continues to challenge both providers and patients. To qualify for reimbursement, a provider must be eligible to use specific diagnosis (International Classification of Diseases-9th Revision [ICD-9]) and procedural (Current Procedural Terminology [CPT]) codes.<sup>49</sup> If the provider, or the codes, is excluded from the benefit plan, the provider is not reimbursed for the services. This reality places providers in ethical quandaries and leads to improper treatment, costly care, inaccurate data and poor outcomes.

#### Service Exclusions

Comprehensive and coordinated treatment of pediatric behavioral health issues often requires provider contact with mental health professionals, primary care physicians, families and schools. However, non-face-to-face components of care are often not reimbursed by the health plan, even though procedural codes exist for these services. Health plans are also more reluctant to reimburse clinicians for nonmedication treatments.<sup>51</sup>

## **Diagnostic Exclusions**

Diagnostic exclusions limit the scope of mental health disorders that will be covered by the health plan.<sup>71</sup> Diagnostic exclusions for disorders that affect learning, such as mental retardation and developmental disorders (e.g., autism),<sup>71</sup> can be applied as a result of Public Law 104-476 (see box 4.4). Exclusions also may limit treatment services for problems such as eating disorders and communication disorders. When present, these exclusions can create barriers for patients seeking care, increase the prevalence of untreated mental health problems, threaten the use of the medical home and challenge coordination of care.

A second form of diagnostic exclusions is that of v-codes. V-code diagnoses listed in the *Diagnostic and Statistical Manual of Mental Disorders*, *Fourth Edition Revised (DSM-IV-R)*<sup>72</sup> are used when a patient presents with a problem that does not meet the minimum threshold necessary for diagnosis. For example, "anxiety problem" has a v-code, while "anxiety disorder" has a standard code. Because reimbursement is tied directly to diagnosis, the exclusion of v-codes from benefit plans creates an ethical dilemma for providers. Some providers will be discouraged from addressing behavioral health conditions in their patient population; others may upgrade the condition to a diagnosis to ensure reimbursement. In multiple studies, the presence

of managed care influenced providers' diagnostic decisions. 73 As compared to clients paying out of pocket:

- a patient presenting with subclinical social phobia was five times more likely to receive a diagnosis when using managed care;<sup>73</sup>
- a patient presenting with subclinical ADHD was 2.8 times more likely to receive a diagnosis when using managed care; and<sup>73</sup>
- a patient presenting with subclinical depression or subclinical anxiety was approximately three times more likely to receive a diagnosis when using managed care.<sup>74</sup>

Patients inappropriately receiving an upgraded diagnosis can face lifelong stigmas associated with the illness. To help reduce diagnosis issues and coding challenges, the American Academy of Pediatrics and other stakeholders in child and adolescent mental health developed the *Diagnostic and Statistical Manual for Primary Care (DSMC-PC)*. The usage of this manual by PCPs will initiate proper diagnostic coding, allow for assessment of outcome, and justify that effective services were provided. 49

## **Provider Exclusions**

While most large employers reimburse primary care providers for the screening, assessment and treatment of mental health disorders, primary care providers may not be reimbursed or may be reimbursed at a lower rate as compared to mental health providers. These realities and perceptions provide primary care physicians a disincentive to address behavioral health conditions in their patient population.<sup>49</sup>

# **SCHOOL-BASED HEALTH SERVICES**

"Schools are where children spend most of each day. While schools are primarily concerned with education, mental health is essential to learning as well as to social and emotional development. Because of this important interplay between emotional health and school success, schools must be partners in the mental health care of our children." President's New Freedom Commission

School-based mental health (SMH) services play an important role in providing pediatric behavioral health care at the school and community levels. The public school system shoulders the responsibility for nonreimbursed specialty care that privately-insured children need. Unfortunately, only 17 percent of school districts currently operate school-based health centers (SBHCs). Furthermore, shortages of schoolemployed mental health professionals (e.g., counselors, psychologists and social workers), contribute to the continued gap between children who need and those who receive effective mental health services.

Ideally, SMH programs should offer the full continuum of services, including environmental enhancement, prevention, assessment, intervention, case management and referral activities. In many SBHCs, mental health care is the most-utilized service.<sup>81</sup>

According to the American Academy of Pediatrics, SMH services should:82

- be coordinated with educational programs and other SBHCs;
- be developed with a health social environment and clear rules and expectations in mind;
- coordinate, monitor and evaluate mental health referrals using written protocols;
- implement specific diagnosis screenings only when they are supported by peer-reviewed evidence for effectiveness in the school setting;
- define the roles of the various mental health professionals who work with students; and
- have providers who are trained specifically in child and adolescent mental health.

There are many advantages to SMH services. Schools are the optimal setting in which to identify at-risk children and promote prevention and intervention programs. BHCs can reduce many barriers for students and families (e.g., knowledge of programs, transportation issues and family-work schedules). In addition, the school setting is familiar to children and adolescents, which may reduce stigma and intimidation. MH programs also enhance opportunities for collaboration between parents, teachers and mental health professionals. 4

## **BOX 4.4. The Individuals with Disabilities Education Act**

In 1975, Congress passed the Education of All Handicapped Children Act (Public Law 94-142) to ensure adequate educational services for children with disabilities.<sup>85</sup> This act was renamed the Individuals with Disabilities Education Act (IDEA) and became Public Law 104-476 in 1990; it was reauthorized in 2004.<sup>85</sup> The IDEA law includes the following 14 categories of specific disabilities, which must negatively affect a child's education performance to be applicable:<sup>86</sup>

- autism
- deaf-blindness
- deafness
- development delay
- emotional disturbance
- hearing impairment
- mental retardation
- multiple disabilities
- orthopedic impairment
- specific learning disability
- speech or language impairment
- traumatic brain injury
- visual impairment including blindness
- other health impairment
  - This category includes limited strength, vitality or alertness (with respect to the educational environment) that results from a health problem such as asthma, ADHD, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia or Tourette syndrome.

Children who are eligible for educational services under IDEA receive these services at no cost.<sup>87</sup> Depending on the child's needs, his or her IDEA services may include transportation, counseling, recreation and enrichment programs, school nurse services, and physical, occupational, and speech therapy.<sup>87</sup>

Many children with disorders that may affect learning ability, such as autism and ADHD, are diagnosed in the educational setting. This provides them with services related to their school performance, but not with other health-related services (i.e., psychiatry).<sup>87</sup> In the case of autism, diagnoses acquired in schools often are not recognized by medical professionals, so the child is not eligible for related healthcare services under an employer's health plan. To become eligible, assessments must be performed in a medical setting—often leading to greater costs and a longer wait for treatment.<sup>88</sup>

## STIGMA

Prevailing and pervasive stigmas associated with mental illness prevent many from seeking treatment.<sup>1</sup> Defined as "a stain or reproach on one's reputation," public stigmas can result in diminished opportunities, ridicule, and social isolation. Privately, stigmas can decrease an individual's self-esteem. 90

The accumulation of negative stereotypes, attitudes and beliefs all contribute to stigma. For child and adolescent mental health, it is not only the child's concerns but also the parent's concerns that are relevant. For example, in a national survey of adults:

- fifty percent believe mental health treatment will make their child an "outsider" at their school;
- more than 50 percent believe that people in the community know the children being treated regardless of confidentiality laws;
- eighty-five percent believe doctors are overmedicating children with common behavior problems;
- nearly 70 percent believe medications will have long-term negative effects on a child's development; and
- more than 50 percent believe that medications for behavioral problems prevent families from working out problems themselves.<sup>91</sup>

## **DISPARITIES**

National data indicate that only a small portion of ethnic minorities receive the mental health services needed. In 2007, Hispanic adolescents (36.2 percent) were more likely to report feelings of depression than blacks (28.4 percent) or non-Hispanic whites (25.8 percent). However, Hispanics, blacks, and Asian American/Pacific Islanders are all less likely than non-Hispanic white children to receive needed mental health services. Health services (25.8 percent) are received needed mental health services.

Several reasons explain the disparate service utilization among minority populations. Most important, parents are the key determinants of service use among children. Cultural stigmas make minority parents less likely to report mental health problems. A lack of diversity among mental health specialists and a lack of culturally competent interventions also result in nonuse and drop outs. In one study, more than 80 percent of Latino adolescents with mental health problems did not get the care needed because of language barriers and a strong cultural stigma of mental illness.

Culturally-appropriate services are needed to enhance the utilization and effectiveness of services provided to minority populations. Culturally-appropriate services "incorporate [an] understanding of racial and ethnic groups, their histories, traditions, beliefs, and value systems." Any provider can be trained in cultural competency; however, many families will still prefer to be treated by a provider of the same ethnic background. Significant research shows that patients and therapists of similar race and gender have better outcomes.

# **Current Challenges, Future Opportunities: Recommendations for Action**

After examining the current state of child and adolescent behavioral health, the Advisory Council discovered several obstacles to purchasing and providing optimal behavioral health services for the pediatric population. These challenges present opportunities for future improvement in the areas of general medical benefits, behavioral health benefits, pharmacy oversight, data collection, collaboration with schools and communities, and workplace programs.

This section is meant to guide employers as they review the structure, purpose, coordination and integration of their behavioral health benefits. Employers are encouraged to assess their existing networks in terms of the specific challenges listed, and if needed, to add these recommendations to contract language with Managed Care Organizations (MCOs), Managed Behavioral Health Organizations (MBHOs), Pharmacy Benefit Managers (PBMs) or other vendors as appropriate. Whenever possible, these vendors should incorporate the recommended standards as part of their normal provider performance review. Employers should require these vendors to present the findings of their review annually.

## RECOMMENDATIONS FOR THE HEALTH PLAN

# **CHALLENGE: Providing a Comprehensive Network of Providers**

Many provider networks lack a sufficient number of trained and culturally competent child and adolescent mental health professionals for referral and treatment.

**Recommendation 1:** Employers should assess their networks for the number of participating providers who are specially trained in child and adolescent behavioral health, active, and accepting new patients. Many providers primarily serve the public mental healthcare system or educational system and are not part of employers' current networks. If needed, employers should direct their MCOs and MBHOs to add providers that can adequately deliver child and adolescent behavioral health services. Networks can add providers using a variety of methods. MCOs or MBHOs can:

- facilitate the utilization and reimbursement of public sector providers (i.e., community health centers, Federally Qualified Health Centers) when necessary;
- add telemedicine as a reimbursable service; and
- add providers on an ad hoc basis to meet geo-access or other specific employer requirements.

MBHO/MCOs should have specific standards for credentialing child and adolescent providers for inclusion in their networks. An adequate number of providers by provider type and geographic dispersion should exist. Employers should work with their health plan to help ensure specific credentials are available to beneficiaries selecting specialty providers.

**Recommendation 2:** Employers should assess their networks for the availability of culturally-competent and ethnically-diverse providers. Health plans can request information from network providers regarding race, ethnicity and language; however, it is often missing from provider credentialing forms. Health plans may also incentivize providers for submitting this information. Employers should consider their own employee diversity when assessing the diversity of providers within the network.

# **CHALLENGE: Ensuring Appropriate Coverage for Necessary Assessment and Treatment Modalities**

Historically, the scope of employer-sponsored benefits has been limited to traditional treatment services such as office-based professional services, partial hospitalization and acute inpatient care. Services needed to improve care may not be covered with traditional plans. Such services include the use of screening assessments that result in v-codes and/or nonreimbursed diagnoses as well as treatment programs that ensure the full continuum of care for the child and adolescent population.

**Recommendation 3:** Employers should ensure reimbursement for screening and assessments in the primary care setting, regardless of the diagnosis rendered. Screening and assessment may result in nonreimbursed diagnoses or v-code conditions; however, providers cannot know the diagnosis without assessing the patient. To encourage assessment of any presenting problem and to avoid artificial diagnosis, providers should at a minimum be reimbursed for the initial session. Employers can make this operational by:

- ensuring payment for screenings and assessments with resulting v-code diagnoses; and
- reimbursing screenings in the same manner as a lab test by implementing appropriate codes.

Employers should work with their health plan to encourage providers to use screening instruments that have been standardized for use in children and adolescents.

**Recommendation 4:** Employers should provide coverage for a full range of treatment modalities to ensure a complete continuum of care. Specifically, children with more severe behavioral health disorders may need targeted clinical case management, family-focused treatment, or multisystemic home-based therapy. They may also need placed into therapeutic foster care, therapeutic nurseries or residential treatment centers (RTCs). The inclusion of these services in standard benefit plans may require flexible benefit structures.

- Employers should assess their network for providers who are proficient in evidence-based therapies, such as cognitive-behavioral therapy, family-focused therapy, parent-training programs and interpersonal therapy.
- Employers should add more intensive care strategies, such as multisystemic home-based therapy, therapeutic foster care, therapeutic nurseries and RTCs to their standard benefit plan as alternative methods of care and allow those who meet medical necessity criteria to use the benefit.
- MCO/MBHOs should encourage providers to use standards for valid and reliable level-of-care recommendations. The standards can be used for initial placement recommendations as well as to determine continuing care needs.

Employers should also ask their MCOs and MBHOs to annually review behavioral health treatment modalities and make recommendations to them about whether these new treatment modalities should be added to their benefit structure. Many evidence-based treatments have not been verified for use in the pediatric population.

## **BOX 5.1. Residential Treatment Centers**

Employers are encouraged to have residential treatment centers (RTCs) available for youth with severe emotional or behavioral disorders who do not respond to other treatment modalities. RTCs are the most restrictive form of care next to inpatient hospitalization<sup>1</sup> and provide a 24-hour structured environment *in combination with treatment*. As such, RTCs differ from programs that provide only housing and care (i.e., boot camps, wilderness programs, etc.). The rehabilitation offered by RTCs may decrease use of acute inpatient services and onerous caregiving necessary to navigate less comprehensive treatment services. Criteria that often trigger admission to RTCs include: Criteria that often trigger admission trigger

- self injury or danger to self;
- physical aggression, assault and danger to others; and
- disruptive and/or destructive acts in the community

Employers are encouraged to use their EAP or MBHO vendors to develop specific protocols for determining appropriate RTC placement, including strict criteria for admission and discharge. RTCs' treatment plans should document specific clinical goals and patient progress toward those goals. The patient and family should be included in this treatment planning. When primary goals are met, and no further evidence of severe impairment exists, discharge should occur with a structured follow-up and aftercare plan in place.

Residential treatment centers should also:

- be accredited by one of the three national accrediting agencies: the Joint Commission (formerly the Joint Commission on the Accreditation of Healthcare Organizations), the Council on Accreditation (COA) or the Commission on Accreditation of Rehabilitation Facilities (CARF);<sup>96</sup> and
- be in proximity to the family home (when possible) to ensure the delivery of family therapy.

## **CHALLENGE: Supporting Collaborative Care**

Strong evidence supports the use of collaborative care for behavioral health disorders in primary care practice settings (e.g., pediatric offices). Employer-sponsored health plans cover collaborative care services if they are delivered face-to-face by a licensed clinician but may exclude:

- coordination and monitoring of treatment by a case/disease manager, particularly via telephone; or
- consultation between a behavioral health specialist and the primary care treatment team, unless it involves face-to-face contact with the patient

Because the public school system often assumes responsibility for specialty care provided above private plan limits, 78 provider communication with these service sectors must also improve.

**Recommendation 5:** Employers should design their benefits plans to reimburse primary care and mental health providers for collaborative care services. Services include non-face-to-face patient time (e.g., telephonic consultation) necessary to coordinate effective care among mental health professionals, school mental health service providers, teachers and parents. Two major mechanisms for payment include the use of:

- clinical CPT codes; or
- administrative payments (such as a case rate) for the management of care by entities such as MCOs, MBHOs, EAP vendors or disease management companies.

**Recommendation 6:** Employers may consider providing a designated case manager who ensures coordination and continuity of care between the various stakeholders. Case managers can be employed

through the EAP or the contracted health plan and should consider developing communication plans for providers, including routine updates to other caregivers.

**Recommendation 7:** Employers should monitor the continuity and coordination of care between general medical and behavioral health services and take action as necessary to ensure seamless, appropriate behavioral health care. Employers should request evidence from their vendors on how they coordinate care with their behavioral health carve-in or carve-out.

**Recommendation 8:** Employers should work with their health plans to provide primary care providers access to a list of in-network mental health professionals who are skilled in the care of children and adolescents, are accepting referrals and are willing to work collaboratively. When a given geographic area has few or no providers, tele-providers should be considered and reimbursed as an alternative.

**Recommendation 9:** Employers should work with their managed care providers to develop a means of releasing/accepting school records to avoid duplicative costs of assessments and screenings. The transfer of records should abide by Health Insurance Portability and Accountability Act (HIPAA) regulations.

# **BOX 5.2. Michelin Health Advocate Program**

One model of care management is exemplified by Michelin's healthcare strategy — *Choose Well-Live Well.* As a part of this strategy, Michelin assigns employees and family members enrolled in the *Healthy Options* medical plan a specific Health Advocate to help beneficiaries navigate the health care system. Health Advocates offer flexible and individualized attention based on the individual's needs. Michelin Health Advocates can:

- assist employees and family members in locating doctors;
- help employees and family members draft a list of questions for the doctor before each visit or provide answers to questions after a doctor visit;
- coordinate care with doctors and other professionals to make sure the beneficiary is getting the care needed:
- direct employees or family members to other Michelin-sponsored health programs and resources available to help them improve their health (i.e. employee assistance program, condition-management programs, health coaching); and
- help assess health needs and address personal health concerns.

Most importantly, an individual's health advocate remains constant so that (s)he can build a trusting relationship and receive continuous support. Michelin utilizes an external vendor to provide health advocates to employees. All health advocates are registered nurses.

## RECOMMENDATIONS FOR EMPLOYER OVERSIGHT

# **CHALLENGE: Confirm Appropriate Care Coordination and Management of Prescription Medications**

There is a lack of standardization and use of best practices in the prescribing of psychotropic drugs and the monitoring of patients prescribed these drugs. Too often, children who are identified as having a behavioral health disorder are not monitored longitudinally for treatment success and compliance. Similarly, patients' treatment plans are often not reviewed or updated.

**Recommendation 10:** Employers should request that their MBHOs, MCOs and Pharmacy Benefit Managers (PBMs) adopt a nationally accepted best-practice guideline for the dispensing of psychotropic drugs to children and adolescents. Of particular importance, guidelines should ensure the safe

prescribing of psychotropics to youth. MBHO/MCOs should monitor the percentage of individuals prescribed psychotropics, the prevalence of polypharmacy and the length of psychotropic treatments.

**Recommendation 11:** The employer should work with their MBHO/MCO to verify that patients prescribed psychotropics are receiving periodic and routine follow-up. The diagnosis, treatment plan and follow-up care should be documented in the patient's medical record, which should demonstrate individual plans of care with specific health outcomes. Employers can evaluate their MBHO/MCO for the percentage of individuals receiving this standard of care.

Employers should request that referrals to specialty care be handled in the following manner:

- At minimum, the physician should document in the medical record that the patient was referred, indicate the reason for the referral and notify the MBHO that a referral was made.
- For best practice, a primary care physician should (with the patient's permission) contact the specialty care clinician and communicate the need for referral and any relevant clinical data. If the resources are available, they should check with the specialist's office to see whether the patient was seen or should contact the MBHO to facilitate follow-up care.
- When the primary care physician remains involved in the patient's care, the specialist should contact the referring primary care physician and communicate the patient's status and the responsibilities of both parties for treatment and follow-up care. All communication should be consistent with HIPAA requirements and any other state privacy or confidentiality guidelines.

# **CHALLENGE: Collecting and Analyzing Data**

Employers often do not receive a full picture of their healthcare claims and pharmacy information. Integrating this information would allow them to identify care gaps and assess the value of their benefits.

**Recommendation 12:** Employers should work with their MBHOs and MCOs to develop a process for coordinating data collection between the MBHO/MCO and the PBM. Combined, these data can be used to assess the adherence to and effectiveness of the mental health interventions. Some analyses employers might consider are:

- the number of children who are receiving psychotropic medications by provider type and by diagnosis;
- the number of children who are receiving psychotropic medications without a behavioral health diagnosis;
- the number of children who are receiving psychotropic medications but no other evidence-based treatments;
- the number of children who are prescribed psychotropic medications but are not filling the prescription; and
- the number of children who are referred to a specialty behavioral health provider but are not seen.

Employers who identify care gaps based on this information should work with their MCOs/MBHOs to develop a plan for performance improvement. They should request annual reports regarding exchange of information between medical and behavioral health vendors.

**Recommendation 13:** Employers should ensure that desired analyses are conducted within the confines of their normal annual contract. Employers should denote reports of interest during contract negotiations; reports beyond that included in the contract can result in unforeseen costs.

# RECOMMENDATIONS FOR THE WORKPLACE

# **CHALLENGE: Improving Work-Life Benefits**

Work-life balance is the main contributor to caregiver burden. Resources made available at the worksite can help decrease caregiver strain, healthcare utilization and workforce reductions, while helping parents and caregivers maintain the financial resources necessary to care for their family.

**Recommendation 14:** Employers should consider implementing policies proven to decrease caregiver strain by improving work-life balance. Policies include:

- flexible leave policies that enable parents/caregivers to seek diagnosis or treatment for their child; and
- flexible work practices (e.g., flex-time, flex-place, job sharing etc.) that assist parents/caregivers in maintaining an income while giving them more flexibility to care for their child (flexible work practices are typically less expensive to the employer than complete replacement of the individual).

**Recommendation 15:** Employers should review the adequacy of caregiver resources available through their EAP. EAP offerings should:

- assess caregivers for anxiety and depression at each visit; caregiver strain can worsen over time and impact the employee and employer;
- emphasize/encourage family counseling when confronting child emotional or behavioral problems;
- provide support services such as assistance locating suitable childcare for children with special needs;
- ensure an inventory of child specialists with a broad range of credentials and ethnic diversity to which parents/caregivers can be referred;
- offer advocacy services (with employee's permission) to support treatment needs to the treating physician, PCP, school, benefits administrator and others; and
- host seminars geared toward childhood issues and/or help caregivers locate local support groups.

# **CHALLENGE: Ensure a Culture of Acceptance and Confidentiality**

Mental disorders continue to be stigmatized. Parents/caregivers worry about the effect of caregiving on their job and about the long-term consequences of their child being labeled with a mental disorder.

**Recommendation 16:** Employers should ensure a culture of health by educating all levels of the organization about mental illness. Education methods should:

- emphasize that mental disorders are diseases of the brain that need to be cared for much like other chronic diseases;
- dispel myths that mental disorders are emotional disorders within an individual's control; and
- promote early recognition and treatment of mental health disorders.

As appropriate, existing EAPs can provide some or all of these services.

# **Summary**

Individuals, families and employers alike shoulder the burden of child and adolescent mental health problems. Children and families are challenged by stigma, a fragmented delivery system and a lack of mental health specialists and standards of care. For employers, a substantial portion of the burden is related to employees who care for a child with a mental health problem. Employers can experience more work absences, reduced productivity and job termination as a result of caregiving parents.

The recommendations in this Guide provide employers with comprehensive strategies for addressing child and adolescent mental health. These recommendations intend to improve the delivery of mental health services to youth, improve caregivers' health and productivity, reduce unnecessary healthcare expenditures and ensure a healthy future workforce. Implementing employer-based strategies through the health plan, EAPs and workplace policies may reduce the impact of child and adolescent mental health problems.

# **Appendix 1: Abbreviations**

ADA ......Americans with Disabilities Act

ADHD......Attention Deficit/Hyperactivity Disorder

CPT.....Current Procedural Terminology

EAP.....Employee Assistance Program

FDA .....Food and Drug Administration

FMLA ......Family Medical Leave

HIPAA......Health Insurance Portability and Accountability Act

ICD.....International Classification of Diseases

IDEA.....Individuals with Disabilities Education Act

MBHO ...... Managed Behavioral Health Organization

MCO......Managed Care Organization

MDD......Major Depressive Disorder

MSMHO.....Multiservice Mental Health Organizations

NCQA ......National Committee for Quality Assurance

OCD.....Obsessive-Compulsive Disorder

PBM.....Pharmacy Benefit Manager

PCP.....Primary Care Physicians

RTC.....Residential Treatment Center

SBHC.....School-based Health Centers

SED.....Severe Emotional Disturbance

SMH .....School-based Mental Health

TBS ......Therapeutic Behavioral Services

# **Appendix 2: Glossary**

Note: Many of the following definitions are taken from the U.S. Department of Health and Human Services' publications.

**Anorexia Nervosa:** An eating disorder characterized by emaciation, a relentless pursuit of thinness and unwillingness to maintain a normal or healthy weight, a distortion of body image and intense fear of gaining weight, a lack of menstruation among girls and women, and extremely disturbed eating behavior.

**Anxiety:** Anxiety disorders have multiple physical and psychological symptoms, but all have in common feelings of apprehension, tension or uneasiness. Among the anxiety disorders are panic disorder, agoraphobia, obsessive compulsive disorder, posttraumatic stress disorder and generalized anxiety disorder.

**Attention Deficit Hyperactivity Disorder (ADHD):** A neurobehavioral disorder characterized by pervasive inattention and/or hyperactivity-impulsivity, resulting in significant functional impairment at home, in school and in relationships with peers.

**Autism:** One of a group of disorders known as autism spectrum disorders (ASDs). ASDs are developmental disabilities that cause substantial impairments in social interaction and communication and the presence of unusual behaviors and interests. Many people with ASDs also have unusual ways of learning, paying attention and reacting to different sensations. The thinking and learning abilities of people with ASDs can vary, from gifted to severely challenged. An ASD begins before the age of 3 and lasts throughout a person's life.

**Bipolar Disorder:** A serious brain illness that is also called manic-depressive illness. People with bipolar disorder go through dramatic mood swings—from overly "high" or irritable to sad and hopeless, and then back again—often with periods of normal mood in between. Severe changes in energy and behavior go along with these changes in mood.

**Bulimia Nervosa:** An eating disorder characterized by recurrent and frequent episodes of eating unusually large amounts of food (e.g., binge eating) and feeling a lack of control over the eating. This binge eating is followed by a type of behavior that compensates for the binge, such as purging (e.g., vomiting, excessive use of laxatives or diuretics), fasting or excessive exercise. People with bulimia can fall within the normal range for their age and weight.

**Depression:** A state of low mood that is described differently by people who experience it. Commonly described are feelings of sadness, despair, emptiness, or loss of interest or pleasure in nearly all things.

**Major Depression:** A depressive disorder characterized by a combination of symptoms that interfere with a person's ability to work, sleep, study, eat and enjoy once-pleasurable activities. Major depression is disabling and prevents a person from functioning normally. An episode of major depression may occur only once in a person's lifetime, but more often, it recurs throughout a person's life.

**Dysthymic Disorder:** A depressive disorder characterized by long-term (two years or longer) but less severe symptoms that may not disable a person but can prevent one from functioning normally or feeling well. People with dysthymia may also experience one or more episodes of major depression during their lifetimes.

**Employee Assistance Program (EAP):** An employer-sponsored service designed to assist employees, spouses and dependent children in finding help for emotional, drug/alcohol, family and other personal or job-related problems.

**Evidence-based Medicine:** The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine

integrates individual clinical expertise with the best available external clinical evidence from systematic research. An intervention is considered "evidence-based" when

- peer-reviewed, documented evidence shows that the intervention is medically effective in reducing morbidity or mortality;
- reported medical benefits of the intervention outweigh its risks;
- the estimated cost of the intervention is reasonable when compared to its expected benefit; and
- the recommended action is practical and feasible.

**Family and Medical Leave Act (FMLA):** Requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons.

**Functional Impairment:** "Difficulties that substantially interfere with, or limit, a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, cognitive, behavioral, communicative or adaptive skills." For example, impairment may limit the ability to function in a classroom setting.

Multiservice Mental Health Organizations (MSMHOs): Multiservice mental health organizations are generally free-standing mental health facilities other than hospitals, such as clinics and residential centers.

Psychotropic Medications: Drugs used to treat psychiatric disorders.

**Schizophrenia:** A mental disorder lasting for at least six months, including at least one month with two or more active-phase symptoms. Active phase symptoms include delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and other symptoms. Schizophrenia is accompanied by marked impairment in social or occupational functioning.

**Substance Abuse:** The harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. It is characterized by compulsive, at times uncontrollable, drug craving, seeking and use that persist even in the face of extremely negative consequences.

# **Appendix 3: ICD-9 Codes**

314.00, 314.01, 314.9	. Attention-Deficit/Hyperactivity Disorder
299.00	. Autistic Disorder
312.81, 312.81, 312.89	Conduct Disorder
313.81	. Oppositional Defiant Disorder
303.9	. Alcohol Dependence
305.00	Alcohol Abuse
304.40	. Amphetamine Dependence
305.70	. Amphetamine Abuse
304.30	. Cannabis Dependence
305.20	Cannabis Abuse
304.20	Cocaine Dependence
305.60	Cocaine Abuse
304.50	. Hallucinogen Dependence
305.30	. Hallucinogen Abuse
304.60	Inhalant Dependence
305.90	. Inhalant Abuse
304.00	. Opioid Dependence
305.50	. Opioid Abuse
304.80	Polysubstance Dependence
296.xx1	. Major Depressive Disorder
296.xxi	. Bipolar Disorder
296.90	. Mood Disorder Not Otherwise Specified
300.3	. Obsessive-Compulsive Disorder
300.02	. Generalized Anxiety Disorder
300.01, 300.21	. Panic Disorder
307.1	Anorexia Nervosa
307.51	Bulimia Nervosa
307.50	. Eating Disorder Not Otherwise Specified

<sup>1</sup> Codes for Major Depressive Disorder are based on severity, current state of disorder, features, etc.

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# **About the National Business Group on Health**

Founded in 1974, the National Business Group on Health is the nation's only non-profit organization devoted exclusively to representing large employers' perspective on national health policy issues and providing practical, forward-thinking solutions to its members' most important health care and health benefits challenges. Members of the Business Group drive today's health agenda while exchanging ideas for controlling health care costs, improving patient safety and quality of care, increasing productivity, supporting healthy lifestyles and sharing best practices in evidence-based health benefits design with senior management, HR professionals, and medical directors from leading corporations. Recognized as the leading voice of large employers, the Business Group represents over 300 members, primarily Fortune 500 companies and large public sector employers, who provide health care for more than 55 million U.S. workers, retirees and their families.

Helen Darling, President.

#### **About the Center for Prevention and Health Services**

The Center houses Business Group projects related to the delivery of prevention and health services through employer-sponsored health plans and worksite programs. Employers should look to the Center for:

- Current information and practical recommendations from both federal agencies and professional associations;
- Analyses of model programs from other employers, and
- Findings from recent clinical and health service research.

For more information, e-mail healthservices@businessgrouphealth.org.

